Arkansas Department of Human Services
DDS Children's Services
P.O. Box 1437 (Slot S380)
Little Rock, Arkansas 72203-1437

INFORMATION REQUIRED TO PROCESS YOUR CS APPLICATION

Dear Parent/Guardian:

The DDS Children's Services (CS) formerly Children's Medical Services (CMS) application that you are completing will be mailed to the CS office in Little Rock where eligibility for the program will be determined on the basis of your child's medical diagnosis and upon certain information you must furnish. Please take this form home and read carefully the list of things below which you are required to do and the information you must mail to the CS office address shown at the top of this page.

1. INCOME VERIFICATION – You are asked to verify your monthly gross income on the application. At that time, you must have the Earning Statement (DCO-97) completed by your employer and returned to CS. This form will be furnished to you if required by CS. Write your child's name and your county of residence in the upper right corner. Write the above address across the top before giving it to your employer.

   If you or your spouse is self-employed, you will be asked to furnish a copy of last year's Federal Income Tax Return, complete with attachments. In addition to this, you may be asked to supply other more current income information.

2. BIRTH CERTIFICATE – You will need to supply a copy of the birth certificate and/or proof of US citizenship for each child for whom you are seeking CS benefits.

3. HEALTH INSURANCE – If your child is covered by health insurance, it will be necessary to supply CMS with a copy of both sides of your child's insurance card. All covered medical services must be billed to your insurance company before being billed to CS. You will also be asked to complete a Third Party Resource form (DCO-662).

4. MEDICAID FOR YOUR CHILD – Because of limited funding, CS will not make payment for medical care that is covered by Medicaid. You may be asked to apply for Medicaid to maintain CS if it appears that you are potentially eligible for Medicaid in any category.

5. SOCIAL SECURITY NUMBER FOR YOUR CHILD – For purposes of record keeping, CS requires a Social Security Number for all children covered by this program. If they already have a number, CS will need a copy of your child's Social Security Card. If they have never obtained a Social Security Number, please be sure to ask the caseworker for a Social Security Number application form for your child. You should complete this form at the time you fill out the CS application. Notify CS of your child's Social Security Number as soon as you receive it.

6. IMMUNIZATION RECORD – CS will need a copy of your child's immunization record.

If you have any questions about the Children's Services program or the information needed for your application, call toll free at 1-800-482-5850, extension 2-2277 (Voice). If you need this information in a different format, such as large print or Braille, please contact your CS office or write to CS at the above address.

DMS-882 (Rev. 07/07)

☐ Initial Application
☐ Reapplication

CMS USE ONLY

DATE

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITY SERVICES
APPLICATION FOR CHILDREN'S MEDICAL SERVICES (CMS)

Phone: 1-800-482-5850 Ext. 22277 or (501) 682-2277 Fax: (501) 682-8247

Section 1: Child's Identification Information

Last Name	First Name	Middle Initial	Date of Birth	Social Security Number	Medicaid Number

Sex	Ethnic Race
☐ Female ☐ Male	☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ White ☐ Other/Specify

Language Spoken In Home	☐ English ☐ Other/Specify

Mailing Address: PO Box or Street	City	Zip Code + 4	County

Residential Address	City	Zip Code + 4	County

Home Phone	Father's Work Phone	Mother's Work Phone	Message Phone

E-mail Address	

Health Insurance ☐ No ☐ Yes/Specify	Name of Insurance Company

Address of Insurance Company	Phone

Name of Primary Person Insured	Policy Number

Section 2: Household Composition Information

Full Name	Relationship to Child	Date of Birth	Social Security Number	Employer	Disease or Disability	Gross Monthly Income

Section 3: Financial Information

Types of Income		Types of Resources		Expenses	
	Gross Amount		Amount		Amount
☐ Child Support ☐ Rental Property ☐ SSA ☐ SSI ☐ Self-employment ☐ Trust Fund ☐ Unemployment ☐ Wages ☐ Annual Income		☐ Bonds ☐ CD's ☐ Checking ☐ IRA's ☐ Land ☐ Mutual Funds ☐ Savings ☐ Stocks		☐ Mortgage ☐ Rent ☐ Vehicles Year/Model ☐ Medical Debt	

PLEASE COMPLETE BOTH PAGES AND SIGN AT BOTTOM OF PAGE 2

Section 4: Medical History

Present Complaint/Disability		
Past/Present Treatment		
Primary Care Physician/Address		
Specialist/Address/Last Seen		
Medications		
Pharmacy		
Therapies	☐ Occupational ☐ Physical ☐ Speech	☐ Other/Specify
School/Day Care Child Attends & Grade		

Section 5: Family/Social History (Why did you apply for CMS? Can you tell us things about your family that will help us serve you better? Such as inability to read or write in native language, work hours of parent/guardians, best time to contact family, family needs such as transportation, locating services or providers, medical equipment, medical supplies, school problems, etc.) Other Assistance applied for

☐ ARKids; date of application ☐ Child Support ☐ DDS/EI ☐ Food Stamps ☐ HUD
☐ SSI; date of application ☐ TEFRA; date of application ☐ WIC

Section 6: Directions to your home

Section 7: Parent/Guardian Agreement (please read carefully)

☐ My child currently has a case manager, whose name is _____.
☐ I choose Children's Medical Services (CMS) to be my child's Case Manager
☐ I do not choose Children's Medical Services (CMS) to be my child's Case Manager

I hereby request that my child be accepted for service coordination, diagnosis and/or treatment as provided by CMS. I understand that I will be expected to apply for Medicaid if eligible or CMS will not be able to authorize any services. I agree to file with my insurance company for any services paid by CMS and reimburse CMS if and when insurance pays (or if is a liability settlement).

I understand that the information contained in the application is confidential and not subject to disclosure except pursuant to law or authorized waiver. I hereby waive such confidentiality and authorize CMS staff to disclose the information herein for the purpose of obtaining services or benefits for my child.

If you need this material in alternate format, such as large print or Braille, please call CMS at 501-682-1461 (voice), 501-682-6789 (TDD) or toll free at 1-877-708-8191 (voice).

_____ _____
Signature of Parent, Legal Guardian or Responsible Party Relationship to Child

_____ _____
Agency Representative Date

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ **Client ID #:** _____
Mailing Address: _____ **Date of Birth:** _____
_____ **Case Head:** _____

I, _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: _____
_____
_____
_____
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): _____
_____
_____

Specific information to be disclosed: _____
"All Medical Records" includes any and all written information you may have concerning my health care and any illness or injury I may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to me.

I understand that this authorization will expire on the following date, event or condition: _____
_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded effective _____ I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act. This letter is available in other languages and alternate formats.

Arkansas Department of Human Services
Verification of Earnings

TO EMPLOYER:
To determine eligibility and correct benefits for your employee we need the information requested below. **This will enable us to ensure that the public funds are used only for the actual and correct benefits to which a household is entitled.** PLEASE COMPLETE THE ITEMS CIRCLED AS WELL AS THE SIGNATURE SECTION AT THE BOTTOM OF THIS FORM.
If you need this material in a different format such as large print, contact your local DHS county office.

_____ **Address** Department of Human Services
Caseworker

_____ _____
Telephone Number TDD#

_____ _____
Employee **Casehead**

_____ _____
SSN of Employee Case Number

1. The above employee began work _____ and earns $_____ per hour. He/she works an average of _____ hours per week. Date first pay to be received _____.
   Anticipated gross amount of 1st pay $_____.
   Employee is paid: ☐ Weekly ☐ Monthly ☐ Other -- Please indicate how often _____
   ☐ Every 2 weeks ☐ Twice Monthly
2. Please show GROSS EARNINGS (before any deductions) PAID TO this employee as indicated. Please list each pay check separately **including vacation pay and bonuses.**

☐ REC'D in the Month of January

☐ For the past _____ consecutive pay periods

Pay Period Ending	Date Received	Hours Worked	Gross Wages	Tips	Housing/Utilities Paid above wages

3. **Earnings:** Are any of the earnings funded by JTPA - On The Job Training Program? ☐ Yes or ☐ No

4. **Termination:** If employee no longer is employed by you, what was the date and reason for leaving this job?
   _____
   Date last check will be received _____ and gross amount _____
5. Additional Information/Expected Changes: (such as layoffs, raises, increased or reduced hours, vacation pay, bonuses, and sick pay).
   _____
6. **Insurance:** If employee has insurance through this job, what is the name and address of the insurance carrier?_____
   Claims processing address if different than insurance carrier _____
   Policy Number _____ Effective date of policy _____
   Type of coverage _____ Policy: ☐ individual or ☐ group
   Policyholder and covered individuals _____
   I do hereby certify that the above information is factual and correct to the best of my knowledge.

_____ _____ _____
Employer/Payroll Clerk Signature Date Telephone

_____ _____
Place of Business Address

DCO-97 (R. 2-91)-100970

ARKANSAS PAC INC.
Parent Advisory Council Inc.

CS Family Member

Please complete and return as soon as possible to: DDS Children's Services, Title V Children with Special Health Care Needs, (CSHCN) P.O. Box 1437-Slot S380, Little Rock, AR 72203-1437. Attn: Parent Consultant

I hereby give Children's Services (CS) Title V CSHCN permission to release my name, address, and phone number to the Parent Advisory Council Inc. for the purpose of informing me of legislative issues, health care issues, parent support group meetings, and other issues concerning my child. If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act (ADA) Coordinator at (501) 682-1461 and 1-800-482-5850, ext. 22277 (voice) or (501) 682-6789 and 1-877-708-8191 (TDD).

PLEASE PRINT

Name of Child: _____

Child's Age: _____

Name of Parent/Guardian: _____

Address: _____

City, State, Zip: _____

County of Residence: _____

Telephone Number: _____

E-mail: _____

Signature of Parent/Guardian: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Languages spoken in the home other than English: _____

School District/Affiliation : _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

CHILDREN'S SERVICES
PARENT ADVISORY COUNCIL
PARENT RELEASE

The Parent Advisory Council Inc. would like your input on training or workshop needs or support group meetings that will help you and your family member who has Special Health Care Needs.

I agree to be contacted by other parents of children with similar disabilities in my area. Yes _____ No _____

I agree to have my name added to a state-wide Parent to Parent contact list. (You will be contacted by the Family to Family Health Information Center for more information.)
Yes _____ No _____

I would be willing to share information and/or experiences about my child's disability. (This might include serving on a council, board or committee.)
Yes _____ No _____

What Affiliations are you involved with? (Support groups, committees, boards, etc.)

_____

Skills and Interests: _____

Profession: _____

Would you attend a support group meeting? Yes_____ No_____

Would you attend a resource workshop? Yes_____ No_____

What time of day is best for meetings/workshops? _____

Specific interests that you have (Example: Estate Planning or Financial Planning):

_____

_____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

DMS-697 (R 2/10)